# MEDICATION ADMINISTRATION INFORMATION

Middleton Cross Plains Area School District

Student Name: ___________________________________ Birth date: _____________ Grade/Teacher: ________

Parent/Guardian Name: __________________________________________________ Phone: _________________

## PRESCRIPTION MEDICATION

Diagnosis:____________________________________________________________________________

| Medication | Dose | Route | Time | Start Date | End Date | Side effects to report to practitioner |
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If the student has an inhaler, may self carry and self administer the inhaler ________ Yes________ No

Practitioner* Name: _____________________________________________ Phone: __________

Practitioner Signature: ___________________________________________ Date: ___________

*Definition of practitioner: physician, physician assistant, advanced practice nurse, optometrist, dentist, podiatrist or chiropractor.

## NON-PRESCRIPTION MEDICATIONS

Non-prescription medication will only be administered in accordance with product instructions . If long term use or a different dosage ( outside of age &weight apporpriate) is needed a practioner order AND signature is required.

| Medication | Dose | Frequency | Start Date | End Date |
|---|---|---|---|---|
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I agree to hold Middleton Cross Plains Area School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of medication as described above at school. I hereby give permission to the school nurse to contact the physician as needed. I hereby give permission to the school nurse to contact the child's physician, if needed. I give consent for this information to be shared with relevant staff. I agree to contact the school nurse if any changes occur with the above request.

**I understand that for safety reasons, ALL medication (prescription or non-prescription) has to be in the original container**. I further understand it is my responsibility to inform the school nurse of any changes to my child's medications.

Guardian Signature: ________________________________________________ Date: ___________

School Nurse Signature:_____________________________________________ Date: ____________